Highmark Inc. d/b/a Highmark Blue Cross Blue Shield | HM Health Insurance Company d/b/a Highmark Health Insurance Company | Highmark Coverage Advantage

# ENROLLMENT/WAIVER FORM

## I EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

| Effective Date | Employer/Group Name | Group Number |
|---|---|---|
| | | |

| First Name | MI | Last Name | Social Security Number *(If no SS#, write N/A)* |
|---|---|---|---|
| | | | |

Address

| City | State | Zip | County | Home/Cell Phone |
|---|---|---|---|---|
| | | | | |

Marital Status *(Please check one)*:
❑ Single/Widowed ❑ Married
❑ Divorced

Special Enrollment Type (if applicable)
❑ Rehired Employee ❑ COBRA Continuant Start Date _____
❑ HIPAA Life Event
*(Please attach a copy of COBRA Election Notice or HIPAA Certificate to support eligibility.)*

| Full-Time Hire (or Rehire) Date *(Month/Day/Year)* | Hours Worked Per Week | Gender |
|---|---|---|
| | | ❑ Male ❑ Female ❑ Non-binary |

| Date of Birth *(Month/Day/Year)* | Product Elections |
|---|---|
| | ❑ Medical Product Name: _____ ❑ Vision ❑ Dental |

## II DEPENDENT INFORMATION (If enrolling more than four dependents, please attach a separate sheet.)

### SPOUSE/DOMESTIC PARTNER

| First Name | MI | Last Name | Relationship to You? |
|---|---|---|---|
| | | | ❑ Spouse ❑ Domestic Partner † |

| Social Security Number *(If no SS#, write N/A)* | Gender | Date of Birth *(Month/Day/Year)* |
|---|---|---|
| | ❑ Male ❑ Female ❑ Non-binary | |

Product Selection(s):
❑ Medical ❑ Vision ❑ Dental

**Note:** †If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.

### DEPENDENT CHILD

| First Name | MI | Last Name | Relationship to You? ❑ Child |
|---|---|---|---|
| | | | ❑ Step-child ❑ Adopted* ❑ Other* |

| Social Security Number *(If no SS#, write N/A)* | Gender | Date of Birth *(Month/Day/Year)* |
|---|---|---|
| | ❑ Male ❑ Female ❑ Non-binary | |

| Product Elections | Dependent Status if Age 26 or Older |
|---|---|
| ❑ Medical ❑ Vision ❑ Dental | ❑ Disabled ❑ Act 4** |

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

## DEPENDENT CHILD

| First Name | MI | Last Name | Relationship to You? ❑ Child ❑ Step-child ❑ Adopted* ❑ Other* |
|---|---|---|---|
| Social Security Number *(If no SS#, write N/A)* | | Gender ❑ Male ❑ Female ❑ Non-binary | Date of Birth *(Month/Day/Year)* |
| Product Elections ❑ Medical ❑ Vision ❑ Dental | | | Dependent Status if Age 26 or Older ❑ Disabled ❑ Act 4** |

## DEPENDENT CHILD

| First Name | MI | Last Name | Relationship to You? ❑ Child ❑ Step-child ❑ Adopted* ❑ Other* |
|---|---|---|---|
| Social Security Number *(If no SS#, write N/A)* | | Gender ❑ Male ❑ Female ❑ Non-binary | Date of Birth *(Month/Day/Year)* |
| Product Elections ❑ Medical ❑ Vision ❑ Dental | | | Dependent Status if Age 26 or Older ❑ Disabled ❑ Act 4** |

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

## III WAIVER OF COVERAGE (Complete this section ONLY if you are declining coverage(s) offered to you AND/OR your family members.)

### MEDICAL

**I HEREBY DECLINE MEDICAL COVERAGE:**

- ❑ For myself
- ❑ For family members **ONLY**:
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

**REASON FOR DECLINING MEDICAL COVERAGE:**

- ❑ I already have medical coverage.
- ❑ I don't have other medical coverage and don't want coverage at this time.

### VISION

**I HEREBY DECLINE VISION COVERAGE:**

- ❑ For myself
- ❑ For family members **ONLY**
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

**REASON FOR DECLINING VISION COVERAGE:**

- ❑ I already have vision coverage.
- ❑ I don't have other coverage and don't want coverage at this time.

### DENTAL

**I HEREBY DECLINE DENTAL COVERAGE:**

- ❑ For myself
- ❑ For family members **ONLY**
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

**REASON FOR DECLINING DENTAL COVERAGE:**

- ❑ I already have dental coverage.
- ❑ I don't have other coverage and don't want coverage at this time.

I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer and that I have declined coverage for myself and/or my dependents as noted above. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment (described below) occurs before coverage will be offered.

*By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly.*

_____ _____

Employee/Contract Holder Signature (please hand sign if this is a paper request) Date

**ONLY SIGN IF YOU ARE WAIVING COVERAGE**

**Special Enrollment Rights:**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your employer or call the toll-free Highmark Member Service number: 1-800-241-5704 (TTY/TDD: Dial 711).

## IV OTHER HEALTH INSURANCE COVERAGE

### Other Group or Non-Group Health Insurance Coverage

| Name of Insurance Carrier | Group Number | Effective Date | Name of Policyholder |
|---|---|---|---|
| | | | |

| Policyholder Date of Birth | Relationship to Policyholder | Policy Number | Policyholder Employment Status |
|---|---|---|---|
| | | | ❑ Active ❑ Retired Date of Retirement: |

### Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

| Name of Subscriber or Dependent | Health Insurance Claim Number | Effective Dates | | | Check (✓) Reason For Medicare Coverage | | | Medicare Supplement or Complement? |
|---|---|---|---|---|---|---|---|---|
| | | Hospital (Part A) | Medical (Part B) | Prescription (Part D) | Age | Disability | End Stage Renal Disease | |
| | | | | | | | | ❑ Yes ❑ No |
| | | | | | | | | ❑ Yes ❑ No |
| | | | | | | | | ❑ Yes ❑ No |

## V IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

**(ALL REFERENCES BELOW TO "HIGHMARK" REFER TO THE HIGHMARK COMPANY FROM WHICH COVERAGE IS BEING REQUESTED.)**

**I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.**

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of the Highmark Notice of Privacy Practices is available on the Highmark Web site, or from the Highmark Privacy Office.

*By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly.*

Employee/Contract Holder Signature (please hand sign if this is a paper request) _____ Date _____

**For New Group Business:** Please send all new business materials (Small Group Business Application, Enrollment/Waiver Forms and all supporting documentation) to the appropriate Highmark Small Group Sales Contact.

**For Ongoing Enrollment:** If adding new employees/contract holders/or dependents to an existing group, please send Enrollment/Waiver Forms to one of the following addresses:

Email: enrollmentandbilling@highmark.com

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, Highmark Coverage Advantage or Highmark Health Insurance Company, all of which are independent licensees of the Blue Cross and Blue Shield Association.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4106.

**Discrimination is Against the Law**

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c’est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d’identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d’assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d’identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d’identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود ( TTY: 711) تماس بگیرید.